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**Nos. 95-1858 and 96-110**

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

**DENNIS C. VACCO, *et al.*, *Petitioners*,**

**v.**

**TIMOTHY E. QUILL, *et al.*, *Respondents*.**

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**WASHINGTON, *et al.*, *Petitioners*,**

**v.**

**HAROLD GLUCKSBERG, *et al.*, *Respondents*.**

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**On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits**

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## BRIEF OF AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, *ET AL.*,* AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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The American Association of Homes and Services for the Aging is joined on its brief *amici curiae* by the following state associations:

Alabama Association of Homes & Services for the Aging
Arizona Association of Homes & Services for the Aging
Association of Ohio Philanthropic Homes, Housing and Services for the Aging
Connecticut Association of Homes & Services for the Aging
Delaware Association of Homes & Services for the Aging
Iowa Association of Homes & Services for the Aging
Life Services Network of Illinois
Louisiana Association of Homes & Services for the Aging
Oklahoma Association of Homes & Services for the Aging
Oregon Alliance of Senior & Health Services
Rhode Island Association of Facilities & Services for the Aging
Tennessee Association of Homes & Services for the Aging
Wisconsin Association of Homes and Services for the Aging

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## INTEREST OF AMICI

The American Association of Homes and Services for the Aging (AAHSA), and its related state associations are national and state nonprofit membership associations that together represent over 5,000 not-for-profit facilities and organizations providing housing, health care, and other services to more than 1,000,000 aging and disabled individuals. Seventy percent of AAHSA homes and organizations have religious sponsors, which include Catholic, Protestant, Jewish, and Muslim denominations. Others are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups.

Many of AAHSA's members are nursing homes. Both its nursing home members and most other members also provide community-based services such as home health care, hospice care for those in the last stages of terminal illness, and specialty care for those with Alzheimer's disease and other forms of dementia. Other members provide housing for low- or moderate-income seniors, often with supportive services (*e.g.*, periodic routine tasks) or more intensive home-based services. Approximately 700 AAHSA members are continuing care retirement communities, which provide "continuum of care" health care and housing on one site for the remainder of their residents' lives: residents maintain independence in their own homes for as long as possible by using home-based services, but they receive skilled nursing home care if needed.

This case is of extraordinary importance to all Americans. It will affect how millions of people view and treat the end of their lives. It may fundamentally alter the

relationship between patient and physician or other caregiver. And it may erode this nation's long-held convictions about the intrinsic value of all human life.

In particular, though, the Court's decision will directly and practically affect all of AAHSA's 5,000 members. AAHSA members' mission is to provide both quality care and a high quality of life for people at the end of their lives. Their residents and clients increasingly choose to die outside a hospital—in an AAHSA member nursing home, housing facility, community care retirement community, or in their private home while receiving AAHSA member services. Most of the individuals they serve are seniors; many are frail and in the last stages of their lives. These individuals are among society's most vulnerable populations. Because such patients will become terminally ill or die while in their care, AAHSA's facilities and service organizations are among the few structures in American society that deal with death, and must directly confront end-of-life issues, on a daily basis.

Based on a report by the AAHSA Commission on Ethics in Long Term Care, and by resolution of its Board of Directors, AAHSA has declared that "all persons are sacred regardless of their physical or mental condition" and that it is "opposed to a physician or other person assisting another in the taking of their own life." App. 1a. Like the American Medical Association, AAHSA distinguishes between physician-assisted suicide and both the withdrawal of life support and the prescription of pain therapy that has an expected but unintended consequence of shortening life; "intention is important," and society has long recognized that the right to be free of bodily contact and to let nature take its course includes a right to refuse medical treatment. *Id.*



AAHSA fears that a decision by this Court establishing an overarching right to physician-assisted suicide would profoundly harm the lives of its members' 1,000,000 residents and clients. Many AAHSA members would undoubtedly exercise their right of conscience and refuse to participate in assisted suicides. But that would not eliminate such a decision's harm. Striking down dozens of State laws against assisted suicide would create a risk, which no regulatory safeguards could eliminate, of decisions for death that are made while a person is clinically depressed, incompetent, or overly vulnerable to coercion by others and by societal expectations. And it would inexorably move homes and services for the aging away from a culture of life, caring, and trust towards a culture of death and distrust.

## SUMMARY OF ARGUMENT

The opinions of the Ninth and Second Circuits mistook the exception for the rule. Only in exceptional circumstances may judges countermand the majority's will as expressed through a democracy. Only in exceptional cases may judges take it upon themselves to solve complex and controversial societal problems—in essence, political questions. Especially when the governing political body is a State and the court is federal, *see Gregory v. Ashcroft*, 501 U.S. 452, 457-59 (1991), the exception must be well grounded in the Constitution and in this Court's jurisprudence. No such exception applies here.

There is no fundamental right to receive assistance in committing suicide. Our Constitution and history not only fail to support such a notion; they flatly contradict it. Nor can any right be deemed nonfundamental but

nevertheless of enough constitutional significance to require a "balancing of interests" or any other form of heightened scrutiny. History and the Court's unbroken precedent contradict even this more limited holding. What is worse, such a holding only *appears* more limited; it would necessarily free courts to balance away any number of State interests in favor of any number of hitherto unrecognized rights. The Ninth and Second Circuit decisions do not merely create this slippery slope; they themselves proceed well down the slope.

Even if there were a right to assisted suicide (fundamental or otherwise), it would give way to compelling State interests. The first is the most compelling interest of all, that of protecting human life. This Court and others have already recognized that a State may assert an interest in protecting *all* human life, without devaluing a particular person's life based on his physical or mental condition. As a corollary, the State has a compelling interest in protecting the lives of individuals who do not make competent or truly voluntary decisions to commit suicide. Even physician-assisted suicide's strongest proponents acknowledge as much. But they fail to acknowledge the experience of AAHSA's members and other health care providers showing that competency and voluntariness are so fluid, complex, and subjective, and terminally-ill patients so vulnerable to pressure, that nothing short of a prohibition on assisted suicide will serve the State's interest. Finally, the State has a compelling interest in maintaining the relationship of trust between organizations that serve the aging and their clients, as well as between physicians and patients. Physician-assisted suicide would poison that relationship



and create fundamental conflict with AAHSA members' missions.

Once the due process question is answered, the equal protection analysis should follow *a fortiori*. Once the distinction between the generally accepted right to refuse life-sustaining treatment and the claimed right to assisted suicide is determined to be constitutionally significant under the Due Process Clause, it is unquestionably rational under the Equal Protection Clause. The distinction also has long been recognized by AAHSA members, physicians, ethicists, legal societies, courts, and democratic majorities. For the Second Circuit to declare all these thinkers' conclusions *irrational*, and for it to miss the glaring inconsistency between its due process and equal protection holdings, reveals the decision for what it is: a novel substantive due process holding in disguise.

## ARGUMENT

### I. THERE IS NO FUNDAMENTAL RIGHT TO ASSISTED SUICIDE, AND THAT CONCLUSION SHOULD END THE INQUIRY.

The primary issue in this case is whether the Federal Constitution confers any right to receive assistance in committing suicide notwithstanding the laws of the many States that still make such conduct illegal and have done so for a very long time. No such right exists, and this Court can create one only if it jettisons firmly-established and unquestioned precedent on identifying which interests receive any sort of heightened protection under the Due Process Clause. Neither *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261

(1990), nor *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), strayed from that precedent, and the Court should not do so now.

Even the Ninth Circuit labeled "not controversial" the Court's description in *Bowers v. Hardwick*, 478 U.S. 186 (1986), of what liberty interests are deemed fundamental. *Compassion* Pet. App. 31a n.16.[1] An interest "not readily identifiable in the Constitution's text" must be " 'implicit in the concept of ordered liberty,' " or, stated differently, " 'deeply rooted in this Nation's history and tradition.' " 478 U.S. at 191-92 (citations omitted). This formulation has a very long pedigree, *see, e.g.*, *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (referring to a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental"), which continues to this day, *see, e.g.*, *Reno v. Flores*, 507 U.S. 292, 301-02 (1993).

Even the Ninth Circuit did not venture to say that a fundamental right to suicide can exist under this standard. Not only is such a right not "rooted in the traditions and conscience of our people," *Snyder*, 291 U.S. at 105, but as numerous academic articles, court decisions, and now briefs to this court detail, both suicide and assisting suicide were widely considered criminal offenses for centuries; states largely decriminalized suicide for reasons other than changed attitudes about its morality, and a large majority of states still make assisting a suicide a felony. *See especially* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1985).

[1] The Ninth Circuit opinions as appended to the Petition for Writ of Certiorari in *Washington v. Glucksberg* are cited as "*Compassion* Pet. App. __." The Second Circuit opinion as appended to the Petition for Writ of Certiorari in *Vacco v. Quill* is cited as "*Quill* Pet. App. __."



Instead, the Ninth Circuit created out of whole cloth a new substantive due process doctrine designed to subvert the purpose behind limiting the range of interests deemed fundamental. According to the court, the identification of a nonfundamental liberty interest unleashes a "balancing test" that still "requires the state to overcome a substantial hurdle in justifying any significant impairment." *Compassion* Pet. App. 33a. The only support the court enlisted for its test was *Cruzan* and the earlier cases recognizing an interest in refusing medical treatment. But those cases cannot honestly be read to treat that liberty interest as anything other than fundamental.[2]

Other decisions directly contradict the Ninth Circuit's imagined framework. Nearly every decision declining to find a fundamental liberty interest simply ends its analysis without performing any scrutiny of the statute. *See, e.g.*, *Bowers*, 478 U.S. at 196 (brushing aside respondent's "assert[ion] that there must be a rational basis for the law and that there is none in this case"). The most this Court has ever suggested is that, if a liberty interest

[2] *See Cruzan*, 497 U.S. at 269 (" 'No right is held more sacred, or is more carefully guarded, at common law . . . .' " (citation omitted)); *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982) (resting on a " 'historic liberty interest' " and an interest "recognized as the core of the liberty protected by the Due Process Clause"); *Mills v. Rogers*, 457 U.S. 291, 301 (1982) ("[T]his interest of the individual is of such importance that it can be overcome only by 'an overwhelming State interest.' " (citation omitted)).

exists that is not fundamental, a law need only be "rationally connected to a government interest." *Reno*, 507 U.S. at 303.

This Court should not follow the Ninth Circuit's attempted lead in creating a balancing test for non-fundamental rights. The Court has limited the list of fundamental rights because "[t]he doctrine of judicial self-restraint requires [it] to exercise the utmost care whenever [it is] asked to break new ground in this field." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Such a balancing test could be applied to an endless list of newly-found interests that could never be deemed fundamental. Courts could then use the test—as the Ninth Circuit did here—to elevate an interest to fundamental status in all but name and to run roughshod over legitimate State interests by denigrating their importance. *Compassion* Pet. App. 63a-114a. Accepting the balancing test would give courts license to sidestep the "guideposts for responsible decisionmaking in this uncharted area." *Collins*, 503 U.S. at 125.

*Cruzan* provides no more support for substantively inferring a right to suicide than it does for creating a new framework for inquiry. The right against physical invasion of bodily integrity, on which *Cruzan* squarely rested its recognition of an interest in refusing treatment, *see* 497 U.S. at 269, simply does not apply to a desire to kill one's self by ingesting death-inducing drugs.

*Planned Parenthood v. Casey* and its predecessors are also not helpful, let alone "prescriptive," *Compassion* Pet. App. 57a, in inferring a right to suicide. The Court has disclaimed the Due Process Clause as a basis for a woman's interest in terminating her pregnancy. The



three Justices announcing the Court's judgment in *Casey* upheld *Roe v. Wade*'s finding of a liberty interest based on a concern for *stare decisis* principles and the Court's legitimacy, "whatever degree of personal reluctance any of us may have" for doing so. *Casey*, 505 U.S. at 854-69; *see also id.* at 871. Four more Justices voted to overrule *Roe*. *See id.* at 944-66 (Rehnquist, C.J., concurring in part and dissenting in part). If the Court today would not on a clean slate find a new fundamental liberty interest in choosing to terminate a pregnancy, it would be quite peculiar to hold that the reproductive choice decisions compelled the Court to find an entirely different new fundamental liberty interest.

Even if used to discern a different liberty interest, the reproductive choice decisions provide little guidance here. The Court has recognized that "abortion is a unique act" and that with pregnancy "the liberty interest of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. Abortion involves ending what the Court has necessarily deemed only "potential life," *id.* at 870, not the fully realized life of a person seeking suicide.

Both the Ninth and Second Circuits rested their decisions on *Casey*'s dicta describing prior privacy decisions as "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy," and "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.* at 851. But *Casey* used that passage to frame its explanation that abortion involves more than "beliefs about these matters"; it is

"conduct" that is "fraught with consequences for others." *Id.* at 851-52.[3]

The lower courts lifted the *Casey* passage out of context and used it as an engine that can mint a practically unlimited number of new fundamental constitutional rights that contradict long-held societal consensus. For "[i]f physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and indeed, the use of illicit drugs?" *Compassion* Pet. App. 10c (O'Scannlain, J., dissenting from denial of rehearing en banc by the full court). Especially in light of the *Casey* opinion's true holdings, this passage cannot be read to overturn decades of constitutional jurisprudence intended to limit courts' temptation to substitute their judgment for that of democratic majorities. This Court should take the opportunity to foreclose such a use of *Casey* by lower courts in the future.

## II. THE STATES' COMPELLING INTEREST IN PROTECTING HUMAN LIFE OUTWEIGHS ANY RIGHT TO ASSISTED SUICIDE.

Petitioners and other *amici* raise several compelling state interests that prohibitions on assisting suicides promote. AAHSA focuses on three: the interest in protecting the sanctity of all human life, the interest in preventing suicides that are not truly made voluntarily by mentally competent patients, and a corresponding interest in pre-

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[3] The Court's list of individuals bearing those consequences, *see id.*, applies with full force to the act of committing assisted suicide.



serving the trust the disabled and aging place in long-term care institutions such as AAHSA's members. A prohibition on physician-assisted suicide is necessary to preserve all human life, to protect against less-than-voluntary deaths, and to ensure that long-term care facilities and services for the aging do not become centers of death and suspicion.

### A. Protecting the Sanctity of All Human Life is the Most Compelling of All State Interests.

The Due Process Clause itself lists life as the first interest worthy of its protection. Prohibitions on suicide reveal that society has long recognized that the State's interest in preserving life can outweigh the individual's desire to die. Nor does the quality of the individual's life eliminate the State's interest; prohibitions on suicide or assisting suicide have never made an exception for terminal illness. *See Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citing several cases and other authorities). Apart from the Ninth Circuit, courts and other thinkers throughout time have recognized that "it would violate the concept of human dignity to measure the value of a person's life by that person's physical and mental condition." *People v. Kevorkian*, 527 N.W.2d 714, 727-28 n.41. (Mich. 1994). Thus the Court in *Cruzan* held that, even when a patient is in a persistent vegetative state, "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." 497 U.S. at 282.

Here, too, the State may assert an unqualified interest in preserving all human life, including that of terminally

ill patients. The Ninth Circuit's attempt to diminish that interest to near-nothing based on its cavalier judgment that the terminally ill patient's life is not worth protecting, *Compassion* Pet. App. 63a-101a, runs counter to *Cruzan* and to an unbroken consensus throughout history.

The Court's reproductive choice precedent firmly supports the State at this point in the analysis. A central principle of cases from *Roe* to *Casey* is that the State's " 'important and legitimate interest in potential life' " becomes paramount upon viability. *Id.* at 871 (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)). Even a terminally ill patient is a viable human life. *Cf. Compassion* Pet. App. 146a (Beezer, J., dissenting) (distinguishing between a patient seeking assisted suicide and a patient on life support by categorizing them as essentially viable and nonviable). The same decisions also acknowledge the State's " 'important and legitimate interest in protecting the health of the pregnant woman,' " notwithstanding the burdens State restrictions place on that very same woman's liberty interest. *Casey*, 505 U.S. at 875-76 (quoting *Roe*, 410 U.S. at 162).

Nothing short of a prohibition on ending a life will further the State's interest in protecting that life. Thus the reproductive choice decisions allow the State to prohibit abortions of viable fetuses. *Casey*, 505 U.S. at 879 (quoting *Roe*, 410 U.S. at 164-65). As in those cases, the State's interest in protecting a viable human life outweighs a burden on any liberty interest a terminally ill person arguably has in assistance to suicide.



**B. States Cannot Practicably Limit Physician-Assisted Suicide Only to Mentally Competent Patients Making Voluntary Decisions.**

*Cruzan* held that Missouri's compelling interest in preserving even vegetative human life outweighed a patient's interest in refusing medical treatment because it helped prevent "an erroneous decision to withdraw life-sustaining treatment," which "is not susceptible of correction." 497 U.S. at 283. Here, as in *Cruzan*, a serious risk of irreversible error exists—a risk that a patient's decision to commit suicide will not be made while he is sufficiently competent or will not be truly voluntary.

The Ninth Circuit cavalierly brushed aside these risks by making the naked assumption "that sufficient protections can and will be developed" to "ensure that the possibility of error will be remote." *Compassion* Pet. App. 103a-104a. The individuals who comprised the New York State Task Force on Life and the Law, with far more relevant experience than federal judges, found such a faith in safeguards "naive and unsupportable." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994). AAHSA members' actual experience with terminally ill residents is similar.

Paradoxically, the same terminal illnesses that place a person within the lower courts' newly-"protected" class often cause clinical depression, neurological dysfunction, and corresponding competency questions. And no question exists that these ailments affect a person's decision to live or die: "patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.* at 13 (footnote omitted). Indeed, 95 percent of

all suicides "have a diagnosable mental disorder at the time of death." *Id.* at 11.

The proper response to a mental ailment is to treat it, not surrender to it. Treatment for clinical depression in particular can produce a complete recovery. Many people who initially express a desire to take their lives later regain their mental balance and regain a sense that their lives are worth living. Even sufferers of Alzheimer's disease, who over the long term face irreversible mental decline, experience day-to-day ebbs and flows in their lucidity.

All agree that a decision to take one's life should not be made while incompetent or clinically depressed. But merely imposing competency requirements on assisted suicide decisions cannot prevent such errors. Both competency and depression exist along subtle continuums that are not susceptible to precise measurement. Individuals can suffer a range from mild depression to psychotic depression; indeed, the same individual may slide from one to the other, with a correlating shift in their competency. And competency is a multifactorial concept; persons can be disabled in some cognitive areas and not others.

Almost all residents of AAHSA members experience what is called "aging in place": they begin their stays competent but *gradually* slide toward incompetency. Many, if not most, reach the point at which they are deemed incompetent before passing away or leaving the facility. At any given time, a facility's staff can identify some residents that are still clearly competent and some that are clearly not, but the majority falls somewhere in the undefined middle.



Competency determinations are problematic in and of themselves. They depend on interview measurements that are highly subjective and highly variable across interviewers. Psychological examination is also particularly susceptible to a diagnosis that merely confirms the examiner's pre-interview expectations. If diagnoses are made by physicians without advanced psychiatric training, the examiner is even more likely to overlook some mental illnesses or other competency factors. A physician also may base a determination on very infrequent contact with the individual; residents receive their daily care from nurses, and physicians may see them as little as once per month.

The risk that this sea of complex subjectivity may obscure the decision to die of a mentally incompetent person—a person who might regain his mental equilibrium and later choose to live—is a compelling reason for a State to enforce a prophylactic rule.

Equally compelling is the terminally ill's extraordinary vulnerability to the overt suggestions of others, to psychological pressure, or to perceived societal expectations that they take their own lives. Here, too, no regulation can assure that such pressures have not caused a less-than-willing suicide.

Terminally ill individuals are often disconcerted, preoccupied, emotionally unsettled, and fully confronting their existence and their mortality for the first time. They are seeking aid and answers from those around them. They are, almost by definition, physically frail—often severely fatigued, in pain, and having trouble performing simple tasks such as breathing, eating, and relieving themselves. They may experience depression or

other mental deficits that do not raise serious competency questions but nonetheless further reduce the independence of their decisionmaking.

Such vulnerable individuals may face pressure to take their lives from several sources. One is the physician herself. The original three-judge panel was correct that "[p]hysician neutrality and patient autonomy, independent of their physician's advice, are largely myths. Most patients do what doctors recommend." *Compassion* Pet. App. 15d. Another source is the individual's family. A family's suggestion may be spurred by a selfish desire to lift the financial and emotional burden of caring for the terminally ill,[4] or merely by an honest belief, not otherwise shared by the individual, that a faster death is better for him.

A third source is society as a whole. Even in the absence of overt or subtle suggestion by medical personnel or family members that taking one's life is "the right thing to do"—even in the presence of statements reassuring the patient that the choice is his—he may feel an unwanted obligation to unburden his family and society of himself. Our choices, even our most important and personal ones, are constrained by accepted norms. We

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[4] Terminally ill patients typically have very high medical costs. Medicare payments provide one indicator: In recent years, expenses for patients in the last year of their lives have accounted for between 27.2 percent and 30.6 percent of all such payments. *See* James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 New Eng. J. Med. 1092 (1993). Society may reasonably consider whether this is the best possible allocation of either public or private resources, but it should not reallocate them by pushing the elderly to kill themselves.



largely do what is expected of us, and the terminally ill may see taking their own lives as expected of them.

Indeed, the very act of constitutionalizing a right to suicide would alter attitudes about what society *expects* of individuals, not just what it *permits*. If this Court affirms the judgments below, physician assisted suicide will be more than an option; the nation's highest court will have declared it a constitutional right of enough weight to overcome the informed judgments of numerous democratic majorities and several admittedly compelling State interests. As one facility staff member has written in correspondence to AAHSA, residents

> may use such an assumption [that there is a Constitutional right to assisted suicide] as a further endorsement that the community also does not believe they have the right to continue to live.

The opinion for the Court in *Casey* relied explicitly on its recognition that the Court's earlier reproductive choice decisions have had such an effect. *See* 505 U.S. at 856 (noting that people have relied on *Roe* to "ma[k]e choices that define their views of themselves and their places in society" and "have ordered their thinking and living around that case"). This Court should not spur society to downgrade the value it places on human life and, by so doing, cause vulnerable, terminally-ill patients to "choose" suicide when they otherwise would not have done so.

One final barrier to true safeguards ensuring voluntariness springs from the intersection of the competency and coercion questions. Because competency determinations are highly subjective, a physician's belief that suicide is the better choice may either color her determi-

nation in favor of finding competency or, in the worst case, provide cover for her decision to act "paternally." Even if regulations require a second opinion, the reality of medical practice is that a physician's colleagues are unlikely to challenge her determination in close cases—especially if she has a hand in selecting the colleague. This level of subjectivity is simply not prone to effective regulation.

The same concerns that are present here—a vulnerable population and subjective, unpolicable questions of voluntariness and competency—have supported prophylactic rules against statutory rape, even though some minors can make competent, voluntary decisions to engage in sex with an adult. This Court should not dismiss such concerns in the context of physician-assisted suicide. Error here leads to an unquestionably wrongful taking of a human life, and lowering that risk is the most compelling of all State interests.

### C. Physician-Assisted Suicide Will Undermine the Trust that the Elderly and Their Families Must Have in Institutions and Organizations Serving Them.

AAHSA's members and other providers of care and services to the aging are dedicated to the preservation and enhancement of each client's life and quality of life. This dedication is reflected in their respective charitable missions and in the care and compassion they show to all whom they serve, particularly the most vulnerable—the frail and infirm elderly who face end-of-life decisions. Congress also has not only acknowledged but mandated



this purpose for Medicare and Medicaid providers.[5] The statutes explicitly place the interest in residents' health and safety above some of their own wishes.[6]

The potential for physician assisted suicide would fundamentally alter the relationship between the aging and the organizations that serve them.[7] If prohibitions on assisted suicide are struck down, these institutions could be asked—and perhaps required—to be the agents of their clients' deaths rather than the protector and enricher of their lives. Such an obligation would conflict irreconcilably with the mission of many AAHSA members, both those that are religiously sponsored and those

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[5] *See, e.g.*, 42 U.S.C. §§ 1395i-3(b)(1)(A), 1396r(b)(1)(A) (requiring a facility to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident"); *id.* §§ 1395i-3(b)(2), 1396r(b)(2) (requiring a facility to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, in accordance with a written plan of care" for each resident).

[6] *See, e.g.*, *id.* §§ 1395i-3(c)(1)(v), 1396r(c)(1)(v) (residents have the right to "reasonable accommodation of individual needs and preferences, except when the health or safety of the individual . . . would be endangered").

[7] Assisted suicide creates an unquestioned conflict with specific norms and rules within facilities for the aging; the very act that may be deemed a constitutional right is otherwise specifically forbidden by regulation. *See, e.g.*, 42 C.F.R. 483.25(l) ("Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose . . . (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued . . . .").

that are not.[8] AAHSA has received many letters from staff at member facilities expressing this view. As one wrote:

> If within our settings suicide is an abetted activity in response to the client's frustration, it can unwittingly become an encouraged activity in response to the agency's frustration. . . . I am unalterably opposed to undermining our few remaining pockets of caring culture by turning them into places of purposeful killing.

Many medical ethicists have written that introducing physician-assisted suicide into the physician-patient relationship will seriously undermine patients' trust that physicians are committed to preserving life, which is at the core of the relationship. *See, e.g., Decisions Near the End of Life*, 267 J. Am. Med. Ass'n 2229, 2232 (1992); *cf.* American Medical Association *Code of Ethics* § 2.211 (concluding that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer"). This breakdown of trust has even more drastic effects on the relationship between AAHSA members and the people they serve.

Unlike the selection of a doctor, the choice to enter a nursing home or other facility for the aging entails a fundamental life shift—uprooting one's home and placing large areas of one's life into the hands of others. Many seniors choose to make this move even when their physical state does not make it necessary because they view it as beneficial; they can trust in a facility's mission of preserving life and health when they entrust their lives to it.

One of this nation's most vulnerable populations relies on AAHSA members to show a compassionate commitment to life at one of its most trying yet precious moments. Especially if residents fear that the choice will be subtly forced upon them, physician-assisted suicide will threaten this relationship and poison the environment in which long-term care and services are provided, to the detriment of both caregiver and recipient. Some caregivers' refusal to participate in assisted suicide would not

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[8] Although the invalidation of statutes *prohibiting* assisted suicide would not *require* facilities to engage in such practices, states may move in that direction in response to this Court's decision. And although religiously-sponsored organizations have a constitutionally protected right to refrain from practices such as assisted suicide that violate their religious principles, the right does not extend to AAHSA members who are not religiously sponsored and who hold the same views on secular grounds.

Even for religiously-sponsored members, the right is not absolute. *Compare Employment Division v. Smith*, 494 U.S. 872 (1990) (finding no Free Exercise Clause violation of generally applicable governmental regulation of conduct) *with* Religious Freedom Restoration Act of 1993, 42 U.S.C. § 2000bb(b)(1) (requiring a compelling interest for regulations that burden religious exercise). If this Court finds a constitutional right to assisted suicide and a state attempts to require facilities to assist, advocates and perhaps courts will use the Court's finding here to argue that the State has a compelling interest in furthering the constitutional right. *Cf. Swanner v. Anchorage Equal Rights Comm'n*, 874 P.2d 274, 279-284 (Alaska) (finding that a compelling interest in preventing marital status discrimination outweighed the defendant's free exercise rights even though marital status has never received heightened constitutional protection), *cert. denied*, 115 S. Ct. 460, 460-62 (1994) (Thomas, J., dissenting from denial of certiorari) (noting the conflict among the courts on this issue).

If this Court finds some right to assisted suicide, it should at the least make clear that organizations serving the aging have a right of conscience to refuse to assist.

prevent the degradation of trust for the profession and aging community as a whole. One facility's staff member put it succinctly in a letter to AAHSA.

> Many of [the people we serve] believe if they enter a nursing home they will not receive compassionate and quality care. Why would we want to add another fear—the fear that we might take their lives?

There is no doubt that the State has a compelling interest in mitigating this fear.

## III. STATES MAY RATIONALLY DISTINGUISH BETWEEN A DECISION TO DECLINE LIFE-SUSTAINING TREATMENT AND ONE TO COMMIT SUICIDE.

The Equal Protection Clause "simply keeps governmental decisionmakers from treating differently persons who are *in all relevant respects* alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992) (emphasis added). This Court has stated many times, in many different ways, the extreme deference courts must pay to the State's determination of what is relevant for line-drawing purposes. A distinction is rational "if there is any reasonably conceivable state of facts that could provide a rational basis"; when there are " 'plausible reasons' " for the State action, " 'our inquiry is at an end.' " *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-16 (1993) (collecting cases; citation omitted); *accord Gregory v. Ashcroft*, 501 U.S. 452, 473 (1991).

In finding an Equal Protection Clause violation, the Second Circuit restated the bare-bones rational basis test but conspicuously omitted mention of the deference due



the State in determining what is rational. *Quill* Pet. App. 21a-23a. Even a cursory examination of the classification at issue confirms that, when such deference is given, prohibitions on physician-assisted suicide must be found constitutional.

The Second Circuit examined state laws that apply equally to all citizens, apart from one small group (people who require life-sustaining treatment). It then performed its own exquisite line-drawing to create a new small group with different, ill-defined, and in some cases unidentifiable characteristics ("mentally competent patients who seek to end their lives during the final stages of a terminal illness" through "prescribe[d] drugs to be self-administered"). *Quill* Pet. App. 4a. The two groups are not coextensive: not all patients who need life-sustaining treatment are terminally ill, *see, e.g.*, *Cruzan*, 497 U.S. at 266-67, and not all terminally ill patients need life-sustaining treatment. Incredibly, the Second Circuit concluded that the Equal Protection Clause *requires* the State to lift the court's newly-created group out of the general citizenry protected by laws against assisted suicide and place them in the small category currently occupied only by patients needing life-sustaining treatment.

Two rational bases exist for distinguishing between the two groups of patients. One is the age-old common law right to maintain one's bodily integrity, as explained so forcefully in *Cruzan*, *see* 497 U.S. at 269; that right comes into play only for patients needing medical treatment to survive. The other is the distinction between affirmatively employing medical science to shorten a patient's life and letting nature, in the form of some otherwise-fatal affliction, take its course. Although these

are thin lines, *see Cruzan*, 497 U.S. at 295-98 (Scalia, J., concurring), they are lines that have been drawn throughout much of history and are drawn today—by AAHSA,[9] by physicians (including groups submitting *amicus* briefs in this case),[10] by academic ethicists, by legal groups such as the American Bar Association,[11] by courts[12] (including this one),[13] by carefully selected interdisciplinary task forces,[14] and by democratic majorities that have criminalized one but not the other.[15]

For three or eight federal judges to declare this overwhelming weight of authority from many segments of society *irrational* is a breathtaking exercise of judicial hubris.

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[9] App. 1a-2a.

[10] *See, e.g.*, American Medical Association, Council on Ethical and Judicial Affairs, *Physician Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 92 (1994).

[11] American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (1992).

[12] *See Compassion* Pet. App. 10c n.12 (citing court decisions). Judge Kleinfeld's analogy to General Eisenhower's decision to launch the Normandy invasion is a powerful dissection of the Ninth Circuit majority opinion's confusion on this issue. *Compassion* Pet. App. 163a (Kleinfeld, J., dissenting).

[13] While assuming a right to refuse treatment, *Cruzan* also noted the many laws criminalizing assisted suicide. *See* 497 U.S. at 279-80.

[14] *See* New York State Task Force, *supra*, at viii, 71.

[15] *See* Thomas J. Marzen, *"Out, Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 806 n.25 (1994) (citing statutes of forty states).



It is even more breathtaking when one realizes that the Second Circuit had already found the distinction to be *constitutionally mandated* under the Due Process Clause. One reaches the Equal Protection Clause issue at all only by first concluding, as the Second Circuit correctly did, that refusing life-sustaining treatment and ingesting poison are different enough to mandate a fundamental liberty interest in one but not the other. The Second Circuit's studied indifference to this glaring inconsistency, coupled with its peculiar balancing of State and liberty interests that would be appropriate only in a substantive due process analysis,[16] reveals a "creat[ion of] substantive constitutional rights in the name of guaranteeing equal protection of the laws," *San Antonio Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1972).

## CONCLUSION

The issue of physician-assisted suicide goes to the heart of our society's values. It is complex and stirs deep passions on both sides. States may choose to sanction the practice, and a few already have. But unless the Constitution says otherwise—and it does not—it is for the States to choose. "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary"—yet the lower courts here have read *Casey* to do precisely that. *Compassion* Pet. App. 162a (Kleinfeld, J., dissenting).

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[16] *Quill* Pet. App. 31a ("What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence . . . ?" (citation omitted).)

This Court should return the federal judiciary to its proper role in our nation's government. The judgments of the courts below should be reversed.

Respectfully submitted,

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# APPENDIX

A-1

## AAHSA Statement on End of Life Decision Making

AAHSA holds that all persons are sacred regardless of their physical or mental condition. Society should ensure decency at every stage of life, but especially at the end of life. Public policy should make it possible for individuals and families to have support during the closing moments of life.

- We affirm that individuals, especially the vulnerable populations served by our members, should neither be enslaved to technology nor assumed to be obligated to use every means to preserve life. We are opposed to a physician or other person assisting another in the taking of their own life.
- We affirm that a person should be able to use medications to relieve pain and discomfort, even if an unintended consequence of such therapy would be that life may be shortened.
- We affirm that intention is important just as we affirm that there is a valid distinction between removing life support and the deliberate use of an instrument or drug to end life. In the former instance, the natural processes attending death are allowed to proceed; in the latter a person causes death by deliberate act.

AAHSA recognizes the diversity of the association membership and the universal desire of its members to provide the most compassionate and positive setting possible for the end of life. As deliberation on these ethical, religious and medical issues proceeds either in legislative

or judicial forums, the association strongly affirms that the members should be in the forefront of pastoral and palliative care.

- We believe that each AAHSA member is responsible for deciding whether and how to participate in societal decision that will determine how the dying process is treated in public policy, and
- We recommend that, at a minimum, each member develop and make explicit its values and perspectives on all end of life decisions so that the consumer, the resident, and the family can make an informed choice about the use of its services.

*Approved by the AAHSA Board of Directors, Oct. 26, 1996*